

Barberton Residential Services Relief Program Application

Age 65 and Older and Disabled Barberton Homeowners

File with the City of Barberton Finance Department

Disabled applicants must complete a Certificate of Disability.

DISCOUNTS: Reduction of monthly curbside trash/recycle rates, reduction in storm water fees, and exemption or deferral of special assessments.

WHAT YOUR SIGNATURE MEANS: By signing this form, you authorize the Finance Department to examine any financial records that relate to your income.

QUALIFICATIONS: To qualify for this program you must be at least 65 years old, have a total income of not more than \$27,000 for the previous tax year, own and occupy your home as your principal place of residence as of January 1 of the year of application, or be permanently and totally disabled.

TOTAL INCOME: Total income includes the income of all owners of the home, and includes the income of the spouse of each owner and must be taken from your federal income tax return. If you did not file a federal income tax return, you must provide proof of income.

Name of Applicant _____ Name of Spouse _____

Address _____ Telephone Number _____

Age of Applicant _____ Date of Birth _____

Age of Spouse _____ Date of Birth _____

Date Home Acquired _____ Parcel # _____

Names of All Owners of Home _____

Income Verification: Please attach a copy of your Federal Income Tax Return for previous year.

If you don't file a tax return, please check box and attach proof of income.

I declare under penalty of perjury that I occupy this homestead as my principal place of residence and that I have examined this application. To the best of my knowledge and belief this application is true, correct and complete.

Signature of Applicant _____ Date _____

Mail completed forms to:
FINANCE DEPARTMENT
RESIDENTIAL SERVICES RELIEF PROGRAM
104 THIRD ST NW
BARBERTON OH 44203

For questions regarding utility bill discounts, call Customer Service 330.753.0328

For questions regarding exemption or deferral of special assessments, call 330.848.6775

CERTIFICATE OF DISABILITY

I (we) hereby certify that _____ is now permanently
and totally disabled by virtue of physical disability or mental disability.

Physician (signature)

Print name of person signing

Psychologist (signature)

Address (please print)

Physician/Psychologist License Number

City/State/Zip Code (please print)

Agency

If Agency, signature/title of person completing form

Date